NJ VICTIMS OF CRIME COMPENSATION BOARD
CLAIM INFORMATION

50 Park Place Newark, New Jersey 07102
1-877-658-2221 www.njvictims.org

New Jersey has a Crime Victim's Compensation Fund to help with costs related to injuries received in a violent crime. To find out more, read this information sheet or call the Victim/Witness office in your County. Addresses and telephone numbers for the County Victim/Witness Offices are included in this packet.

How much help can I get from the New Jersey Victims of Crime Compensation Board?

If you qualify, these are some of the expenses that can be paid.

- Psychological counseling
- Loss of support or earnings
- Hospital, physician and physical therapy
- Nursing care
- Care of child or dependent
- Funeral expenses up to $5,000
- Emergency Relocation Costs
- Attorney fees for assistance in filing a claim and representing you in the appeal process

How do I qualify for financial help?

If you are a victim or claimant (person filing for a victim or dependents of the victim), you must show that:

- You are a resident of the State of New Jersey or the crime occurred in this state.
- You have financial losses as a result of injuries you received as a result of a violent or certain other crimes.
- The crime was reported to law enforcement within 3 months, if possible and you submitted this application within 2 years from the date of the crime, if possible.
- You cooperated fully with the police and prosecutor's office. However, eligibility is not dependent upon conviction or prosecution of the offender.
- You or your immediate family member have incurred, or will incur, medical, counseling, funeral bills lost time from work and/or other losses because of injuries directly resulting from the crime.
- You cooperated with the Board investigator and informed the Board of any change of address.
- Insurance and other payment sources such as restitution paid by the offender will not cover the bills submitted.
- You did not contribute to your injuries, provoke the incident, and were not responsible for or participated in the crime that caused your injuries.
- You do not have any outstanding VCCB assessments imposed for convictions. If you cannot provide proof to the Board that they were paid, the outstanding amount will be deducted from your compensation award.

What losses are not covered?

- Property damage or loss, except crime scene cleanup.
- Pain and suffering.

COMPLETING THE APPLICATION...

How can I get help with this application?

Law enforcement agencies, your County Office of Victim/Witness Advocacy or Call us at **1-877-658-2221**.

If I want to apply now, what should I do?

Read the following instructions and fill out the attached claim application. Also include copies of as much related information (i.e. copies of itemized receipts, bills, insurance statements) as you have. The more information we have now, the sooner your application can be processed. You can send more itemized bills later as you receive them.

The VCCB will send you a letter when your application is received. If you have not received a letter after four weeks, please call the VCCB. Keep in touch. If you move or if your phone number changes, please let us know.

CLAIM APPLICATION INSTRUCTIONS

Section One "Victim"

Print the name of the person injured at the crime scene. This should be the same person listed as the "Victim" on the law enforcement report. Complete the rest of this block with information about the victim.

Section Two "Claimant"

Print the name of the person applying for compensation if different than the victim. This person could also be the adult assuming responsibility for the crime-related bills or the financially responsible person (e.g. parent, guardian, spouse) of a minor, incapacitated or incompetent person injured as a result of the crime.

Section Three "Crime"

Print details about the crime here. Attach a copy of the incident report. If you don't have one, the VCCB will request one from the police and/or prosecutor. The law enforcement incident report on the crime is necessary to determine your eligibility and process the claim.

Section Four "Expense"

List the names of doctors, hospitals and others who have provided services. If you already have itemized bills, please send copies with your application. If you have not received bills, do not wait on them. You may send copies later as you receive them. The VCCB can only pay for counseling from a licensed counselor. The VCCB will send your counselor a psychological assessment form to be completed relating the mental health treatment to the crime. This form must be completed by your counselor.

Section Five "Insurance"

If you have insurance that may cover some of your crime-related bills, list your insurance information here.

Section Six "Employment"

List your job information if you have not been able to work because of crime-related injuries or to take care of someone with crime related injuries. Your employer will need to complete an Employer's Questionnaire, giving us your average weekly wage and time missed from work. The doctor treating the Victim will need to complete the Physicians Report, telling us that the absence from work is medically necessary because of the crime.

Section Seven "Civil Action"

If you hired a lawyer to represent you in this claim before the VCCB or to settle an insurance claim or file a lawsuit related to this crime, complete this section.

Section Eight "Referral Source Information"

Print the name of the victim advocate or other professional who assisted you with this application.

Section Nine "Legal responsibility and Signature"

This application is a legal document that must be read and signed by the adult Claimant.

Section Ten "Authorization to obtain records"

This Authorization to Obtain Records is necessary to obtain information from your doctors, hospital, employer, police and prosecutor, so that the Board can process your claim.

Section Eleven "Assignment of Interest"

This is a legal agreement that must be signed in order for the VCCB to pay compensation to you.

Section Twelve "Authorization for release of information under the Health Insurance Portability and Accountability Act"

This authorization is necessary to obtain information from your health care providers under a new federal law. It must be completed, signed and dated in order for the Board to process your claim.

SECTION 10 AUTHORIZATION TO OBTAIN RECORDS

I authorize the NJ VICTIMS OF CRIME COMPENSATION BOARD or it's agent, representative or bearer to inspect, review and make copies, including photostatic copies, of all medical records and records pertaining to employment, earnings, income or grant from any agency, attendance and any other records pertaining to or related to employment or economic assistance, and police and prosecutors reports necessary to determine qualification for my claim for compensation.
Photostatic copies of this authorization will be considered as valid as the original.

X _____

Signature of Victim/claimant Date

Legal representative must sign if the Victim is under 17, legally declared incompetent or deceased.

SECTION 11 ASSIGNMENT OF INTEREST

I, _____, understand that New Jersey law requires me to repay the NJ Victims of Crime Compensation Board (VCCB) for any monies I may receive from other sources in addition to the award from the Board. I shall contact the Board upon receipt of such additional monies from the offender, civil law suit, restitution, insurance program, or any other governmental or private agency.

I further assign and give to the VCCB the right to be directly reimbursed for two-thirds of the VCCB's award to me from the proceeds of any civil law suit I have or will start arising out of this incident.

I also assign and give to the VCCB the right to be reimbursed from Probation, the Juvenile Justice Commission, the Department of Corrections for the amount to be paid to me in the way of restitution ordered by the court in any criminal proceedings related to the incident. Reimbursement to the VCCB shall be limited to any of my out of pocket expenses for which the Board has awarded me compensation.

I certify that I am signing this Assignment of Interest freely and voluntarily. I understand that this Assignment must be signed in order to receive compensation. I further certify that if at any time I initiate a civil lawsuit, I will provide a copy of this Assignment of Interest to my attorney with the instruction that my attorney is bound by it's terms. I understand that VCCB is relying in good faith on this Assignment in order to pay compensation to me.

X _____

Signature of Victim/claimant Date

Legal representative must sign if the Victim is under 17, legally declared incompetent or deceased.

STATE OF NEW JERSEY
Victims of Crime Compensation Board

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www.njvictims.org

SECTION 12 AUTHORIZATION FOR RELEASE OF INFORMATION UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

Patient's Name	Date of Birth	SSN
Address	**Medical Record Number**	**Telephone No.**

I authorize the use and disclosure of health information about me as described below**

Facility Authorized to Release my Health Information:

Agency or Individual (s) Authorized to Receive my Health Information: State Of New Jersey Victims Of Crime Compensation Board

Health Information that may be used/disclosed is limited to the following:

❑ Discharge Summary ❑ Consultation (s) ❑ Pathology Report ❑ Lab
❑ History & Physical ❑ Operative Notes (s) ❑ Imaging/X-ray ☒ Entire Record
❑ Other (specify)_____

Health information that may be used/disclosed is limited to the following Treatment Dates:

_____

Health information to be released to the above named agency/individual is to be used/disclosed for the following purpose (s)(include Research or Marketing, if appropriate): To determine the amount of compensation the patient is entitled to receive, including the payment of any outstanding bills for services rendered by the facility to the patient.

Health information identifies you (the patient) by name, and includes other demographic information about you. Health information may include, but is not limited to: medical records, x-ray films, slides, tracings, strips, etc.

I hereby discharge the releasing facility its agents and employees from any and all liabilities, responsibilities, damages and claims which might arise from the release of information authorized herein, *to include alcohol, drug abuse, communicable disease including HIV status, and/or psychiatric diagnoses* compiled during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility.

Protected Health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by this privacy rule. If research-related Health information is used or disclose forcontinued research purposes, a expiration date or event does not apply.

This authorization will automatically expire 60 days after the date below (except as indicated above), unless an earlier dates is specified, or at the conclusion of a specified event. I understand that I have a right to revoke this authorization at any time, in writing, as stated in the Notice of Privacy Practices, except where the facility has already made disclosures in reliance upon my prior authorization.

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining an authorization if the health information Portability Accountability Act prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage.

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information is to be treated in accordance with Health Insurance Portability and Accountability Act (HIPPA) privacy regulations.

Patient's or Authorized Personal Representative's Signature X	Date	Time ❑ AM ❑ PM
Relationship to Patient / Authority to Act on Patient's Behalf	Interpreter, if utilized	
Witness Signature X	Expiration Date or Event	

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CLAIM INFORMATION

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Claim Application

For Office use only: Application No._____ Claim No._____
Death_____ Personal Injury_____ E.S.C. _____

Please call our toll free number **1-877-658-2221** or your local Victim-Witness Office (phone numbers attached to this application) for help with completing this form.

SECTION 1 VICTIM INFORMATION:

The victim is the same person listed as a victim on the crime incident report. (If more than one victim please complete a separate application for each victim.)
Mr. / Mrs. / Ms. (Circle One)

_____
Full Legal Name Name as it appears on the incident report

_____
Social Security Number Date of Birth

Check if Victim is: ___deceased (Date of death _____) ___under 17 ___incompetent ___disabled

Relationship of victim to the offender, if any _____

_____
Home Mailing Address City/County State Zip Code

_____
Home Telephone Number Work No. Cell phone No. email

Other contact name, address and telephone number(s) that victim is comfortable with Board trying to reach him/her.

_____
Home Mailing Address City/County State Zip Code

_____
Home Telephone Number Work No. Cell phone No. email

This information is requested for statistical reporting purposes, and is optional: Sex: ___Male ____ Female
Race: Caucasian _____African American_____Latino/a_____Native American_____
Asian or Pacific Islander_____ Other _____

Check services requested:

_____ Medical
_____ Lost Wages/Support
_____ Emergency Relocation
_____ Mental Health Counseling
_____ Funeral
_____ Dental
Other: _____

SECTION 2 CLAIMANT INFORMATION:

The claimant is the person applying for compensation if different than the victim. It includes an adult assuming responsibility for the crime-related bills and/or the adult that has custody of a minor.
Mr. / Mrs./ Ms. (Circle One)

_____

Full Legal Name | Social Security Number | Date of birth

The claimant is the Victim's _____ Spouse _____ Parent _____ Sibling _____ Child _____
Other: _____

_____

Home Mailing Address | City/County | State | Zip Code

_____

Home Telephone Number | Work No. | Cell phone No.

SECTION 3 CRIME INFORMATION

(Attach a copy of the law enforcement incident report, if available)

_____

Date of Crime | Date Reported | Name of Law Enforcement Agency

_____

Location/Address of Crime | City/County | State

Police Complaint No. _____ Prosecutor's File No. _____

Type of Crime:

____ Assault
____ Sexual Assault
____ Domestic Violence
____ Homicide
____ DWI
Other_____

_____

Brief Description of Incident

Please describe your injuries.

_____

_____

_____

Name(s) of Offender(s), if known.

_____

If the crime was not reported to law enforcement within three months or if this claim was not filed within two years after the crime please explain why:

_____

SECTION 4 CRIME-RELATED EXPENSE INFORMATION

Attach copies of itemized bills, and additional pages as necessary
Name of doctor/hospital/counselor/funeral home

_____

Address

_____

Phone Number Date

SECTION 5 HEALTH INSURANCE/BENEFITS INFORMATION

List Health, Life and Automobile Insurance policies including Medicaid and Medicare with policy or identification number.

Insurance Policy Number

_____

_____

_____

If you checked life insurance, was there a double indemnity clause? Yes ___ No ___

If Yes, what was the amount paid out under that portion of the policy? $_____

If you do not have insurance, did you apply for charity care? Yes____ No____

SECTION 6 LOST WAGES/SUPPORT INFORMATION:

Complete if you have lost time from work because of your injuries or to take care of an injured victim.

_____

Employee's Name Employer's Name Telephone Number Fax

_____

Name and Address of Company/Business (If more than one employer, please attach additional sheets)

Dates absent from work due to crime related injuries: From _____ To _____
If injured on the job, does your employer have Worker's Compensation? Yes ____ No____
Have you, or will you, apply for State or Private Disability for reimbursement for lost wages?
Yes ___ No ___ If YES, supply all notices received from State Disability or a private disability plan.

Is your household losing income/paychecks due to the crime? Yes____ No____
Are you missing work to care for the victim? Yes ____ No ____

If available, please supply your pay stubs from the week before the crime, the week you returned to work and a letter from your doctor stating your period of disability.
If you are self-employed, you must supply copies of your income tax returns for the last 2 years.
Loss of support may be awarded for dependents of homicide victims. Please supply copies of the victim's income tax returns for the last three years.

SECTION 7 ATTORNEY INFORMATION

If you are represented by an attorney in this claim with the VCCB please complete:

_____

Name of Lawyer Address

_____

City State Zip Code

(_____)_____

Phone

Have you hired a lawyer to settle with insurance or file a lawsuit? Yes ___ No ___

If yes, please provide:

_____

Name of Lawyer Mailing Address Telephone Number

Docket # (If available)_____

I intend to file a lawsuit at a later date Yes____ No_____

Restitution has been ordered and will be paid to me Yes____ No____

SECTION 8 REFERRAL SOURCE INFORMATION

Who referred you to VCCB? Police_____ Friend/Relative_____
Victim Witness Coordinator _____ Domestic Violence/Rape crisis Center_____
Prosecutor _____ Hospital _____ Funeral Home_____ Other_____

SECTION 9 LEGAL AUTHORIZATION AND SIGNATURE

This is a legal document which must be signed by an adult

* Program Qualification: I understand that I am responsible for all bills and the compensation program is designed to pay certain costs not covered by another source. Submitting this application does not entitle me to benefits.
* Possible Repayment: I agree to repay the Board if I receive money from another source up to the amount paid on my behalf. This includes any payment I may receive from the offender, any insurance policy or settlements, judgments, or civil law suits.

The information I have provided in this application is true and correct to the best of my knowledge under penalty of law

X _____

Signature of Victim/Claimant Date

Legal representative must sign if the Victim is under 17, legally declared incompetent or deceased.